



EMPLOYER'S REPORT ON ACCIDENT AT WORK

Instructions for Completing This Form

1. The National Insurance Regulations require that all accidents be reported by the employer. The employer must investigate the accident before completing this form.
2. The entire form is to be completed by the employer or his agent.
3. Submit the form immediately or within one (1) month of the date of accident to the nearest National Insurance Local Office to avoid delay in the processing of the claim; failure to submit this form within the specified timeframe may result in the imposition of penalties (fines of up to \$500).

SECTION A: EMPLOYER INFORMATION

Business Name: _____

Registration No.

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Street Address: _____ P.O. Box: _____

Tel. No.: _____ E-Mail: _____

Nature of Industry of Business: _____

SECTION B: INJURED EMPLOYEE'S INFORMATION

Name: _____ N.I. No.

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Street Address: _____ P.O. Box: _____

Tel No.: _____ (h) _____ (w) _____ (c)

E-Mail: _____

Occupation: _____

What are the duties of the employee: _____

Date of Accident: ___/___/___ Time: _____ a.m./p.m.
dd mm yyyy

Place of Accident: _____

Description of apparent Injury/incapacity: _____

Was the person:

- (a) Employed by you on the day of the accident? Yes No
- (b) A Partner, Director or Sub-Contractor? Yes No
- (c) Involved in an accident that took place while working on the date mentioned? Yes No

What hours was the person expected to work that day? From _____ a.m./p.m. to: _____ a.m./p.m.

SECTION C: REPORT OF ACCIDENT

1. When was the accident first reported? Date: ___/___/___ Time: _____ a.m./p.m.
dd mm yyyy

2. (a) Was the accident reported to you? Yes No

(b) If not, to whom (please print the name and position of the person):

3. If the accident was not reported on the day it happened, state why: _____
